STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 01 B. WING	01/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/15/13 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Glenbrook Rehabilitation & Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 90 and had a census of 72 at the time of this survey. All areas where the residents have customary access are sprinkered. All areas providing facility services are sprinklered, except the Administrator's office closet. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/22/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 Therapy room corridor door sets closed and latched into the door frame. This deficient practice could affect residents in the Therapy room which has a capacity of 5 residents. Findings include: Based on observation and interview with the Maintenance Director on 01/15/13 at 1:58 p.m., he acknowledged the double corridor doors entering the Therapy room were not equipped with positive latching hardware.	K0018	1. The therapy door has had a latch placed on the door. 2. All corridor doors have been reviewed for appropriate latching doors. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that all doors installed in corridor spaces will have positive latches. The Maintenance Director will check corridors monthly that positive latching hardware is in place and latching properly. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. Feb 3 rd 2013	02/03/2013

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	3.1-19(b)			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure 2 of 7 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect 12 residents in the 300 hall and any number of staff and residents in the Administration hall. Findings include: Based on observation with the Maintenance Director on 01/15/13 from 1:45 p.m. to 1:55 p.m., the 300 hall north exit door and the administration hall exit door, which were equipped with electromagnetic locks, would not release after pushing the door for 15 seconds. When tested by the Maintenance Director at the time	K0038	1. The identified corridor doors were addressed to ensure proper function on January 22 nd by IEI. The identified door lock to the bathroom was flipped so that the lock was on the inside of the bathroom. 2. All corridor exits were reviewed for proper function. Also all bathroom doors were reviewed for locks. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that all exit doors need to release appropriately and that locks on any resident area was be installed in a way not to lock a resident in. All exit doors will be checked for proper release monthly with every fire drill. If any further locks are installed to resident bathroom the Administrator will make a second inspection upon completion to ensure resident safety. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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	of observations, he acknowledged neither door released after 30 seconds. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the exit egress path from 1 of 45 resident room restrooms was readily accessible at all times. This deficient practice could affect 2 of 72 residents. Findings include: Based on observation and interview with the Maintenance Director on 01/15/13 at 12:45 p.m., he acknowledged the door knob on the restroom door of resident room 103 could be locked from the outside requiring a tool to open the door from in the restroom. 3.1-19(b)			

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K0056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 closets in the Administrator's office in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect 1 or possibly 2 residents in the Administrator's office. Findings include: Based on an observation and interview with the Maintenance Director on 01/15/13 at 2:46	K0056	1. On January 24 th a sprinkler head was installed in the Admistrator's closet. 2. PIPE and the maintenance Director made rounds and no further areas were identified. 3. PIPE will continue to monitor sprinkler heads biannually in the facility. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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	p.m., he acknowledged the closet in the Administrator's office lacked sprinkler coverage. 3.1-19(b)			

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K0062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 5 of 6 sprinkler gauges were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 01/15/13 at 1:42 p.m., five sprinkler gauges had a manufacture date of 2007. Based on an interview with the Maintenance Director at 2:58 p.m. during the exit conference, he was unable to provide documentation to confirm the sprinkler gauges had been calibrated or replaced. 3.1-19(b)	K0062	1. All identified gauges were replaced on January 24 th by S&S 2. There are no other gauges in the facility. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that gauges need calibrated or replaced every 5 years. PIPE will be reviewing the identified gauges annually for appropriate calibration or change every 5 years. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 laundry room portable fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice could affect 20 residents on the 100 hall in the event of an emergency requiring evacuation through the services hall. Findings include: Based on observation with the Maintenance Director on 01/15/13 at 2:08 p.m., the fire extinguisher mounted on the wall in the folding room of the laundry area measured five feet ten inches from the floor to the top of the fire extinguisher. Measurements	K0064	1. The identified fire extinguisher was lowered. 2. All remaining fire extinguishers were checked for proper placement. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that all fire extinguishers need to be placed no more than 5 feet off the ground. During monthly fire extinguishers checks will ensure proper height of all fire extinguishers. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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	were provided by the Maintenance Director. 3.1-19(b)			

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	Based on observation and interview, the facility failed to ensure 2 of 9 filters in the kitchen hood system were baffle filters. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 3.1 states mesh filter shall not be used. This deficient practice could affect any resident in the dining room with a capacity of at least 20 residents and kitchen staff in the event of an emergency. Finding include: Based on observation of the kitchen hood system with the Maintenance Director on 01/15/13 at 2:06 p.m., two mesh type filters were in use. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K0069	1. The identified filters were changed for the proper filters 2. There are no other hoods. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that hood must have appropriate filters placed. These filters will be checked with routine required inspections by Degreasing Engineers of the hood system. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.	K0144	1. The generator was tested and held the required load on January 28 th 2013 2. The records for 2013 are up to date. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 1/28/13 that the generator must have a documented load test monthly. The Executive Director will review the documentation monthly for 3 months to ensure consistent recordings of the load tests. If 100% compliance the Executive Director will check quarterly for 6 months. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 3 rd 2013	02/03/2013

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	Findings include: Based on record review of the generator "Weekly Exercise/Monthly Load Test Log" with the Maintenance Director on 01/15/13 at 11:35 a.m., a monthly load test was not conducted for the months of April, May and September of 2012. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review. 3.1-19(b)			

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 of 72 residents and any number of staff. Findings include: a. Based on observation and interview with the Maintenance Director on 01/15/13 at 12:55 p.m., he acknowledged a refrigerator was supplied electricity by an extension cord power strip in the south medication room. b. Based on observation and interview with the Maintenance	K0147	1. Both identified cords where removed. 2. An audit was conducted through the facility and no further cords were identified. All residents have the potential to be affected. 3. Maintenance will conduct rounds monthly to ensure all high current and medical equipment are plugged in correctly.. Staff Development will educate staff on the proper use of extension cords on February 5 th 2013. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed. 4. Feb 5th 2013	02/05/2013

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	Director on 01/15/13 at 1:30 p.m., he acknowledged a concentrator was supplied electricity by an extension cord power strip in resident room 227. 3.1-19(b)			